STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155740	A. BUILDING _____ B. WING _____	02/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREST CHURCH OF BRETHREN	2201 EAST ST NORTH MANCHESTER, IN46962

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: February 21, 22, 23, 24, and 25, 2011 Facility number: 000448 Provider number: 155740 AIM number: 100275140 Survey team: Kim Davis, RN,TC Vicki Bickel, RN Julie White, RN (2/21, 2/23, and 2/24, 2011) Census bed type: SNF/NF: 55 Residential: 153 Total: 208 Census payor type : Medicare: 3 Medicaid: 23 Other: 182 Total: 208 Sample: 14	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	Supplemental sample: 1 Residential sample: 7 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed 3/2/11 by Jennie Bartelt, RN.			

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F0157 SS=D	Based on interview and record review, the facility failed to ensure the resident's family was notified timely when the physician ordered a change of pain medication based on the family's approval for 1 (Resident #16) of 14 residents reviewed in a sample of 14 for physician/family notification. Findings include: Resident #16's clinical record was reviewed on 2/21/11 at 1:20 p.m. Diagnoses included, but were not limited to, Lewy body disease, anemia, intracranial bleed, hypertension, degenerative joint disease, anxiety, osteopenia, depression, atrial fibrillation, osteoporosis and hypothyroidism.	F0157	The policy for notification of family or legal representatives in the event of: 1) an accident which results is injury or has the potential to require physician intervention; 2) a significant change in the resident's physical, mental or psychosocial status; 3) a need to alter treatment significantly or; 4) a decision to transfer or discharge the resident will be revised as follows:I. As soon as it is determined that an event requiring the notification of the family or legal representative has occurred, a call will be placed to the number on file for this individual. A. If contact is made, the notice will be given. 1.The date, time and nature of the notice will recorded in the nurses' notes. B. If there is no answer, a message will be left, if possible, asking for a return call. 1. A call will placed to an alternative number (i.e. cell phone) if such a number is available. If there is no answer at this number, a message will be left if possible. This will be documented in the nurse's notes. C. If a message is left and there is no return call within twelve hours, a second attempt will be made to make contact. If contact is made, the notice will be given and documented in the nurse's notes. **1. If in the judgment of the nurse the nature of the event warrants immediate contact, more**	03/27/2011

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	The clinical record indicated a nurse report/physician update form, located in the physician orders/progress notes was sent to the physician on 12/21/11. The report indicated, "knee pain. client receiving Tylenol 500 mg 2 tabs po (oral) tid (3 times a day). has begun c/o (complaining of) knee pain. would you consider adding or changing tx (treatment)? Also using blue stop gel (analgesic rub) bid (2 times daily) et (and) k-pad (heated water pad) just added as n/o (new order)." The report was signed by the hospice nurse and the facility staff Licensed Practical Nurse (LPN) #3. The record indicated no nurses notes from 12/15/11 to 12/31/11. The hospice notes dated 12/21/10 indicated pain		**frequent attempts at contact will be initiated. The Director of Nursing can be called if contact with the family or legal representative is not made.** D. For less urgent notifications, if there is no return call within twenty-four hours of the initial attempt to make contact, an attempt will be made to contact an alternate family member or legal representative, if there is one. 1.If there is no secondary contact person, or if the attempt to reach them fails, the matter will be referred to the Director of Nursing or their designee for resolution. E. If a change of treatment is being delayed pending notification of the family or legal representative and contact is not made within twenty-four hours, the physician will be notified.The policy will be revised and all professional nurses will be inserviced on the changes by March 27, 2011. Monitoring: A sample of five resident records will be reviewed monthly for six months to assure compliance with this procedure. The results will be reported to the Quality Assurance Committee at its quarterly meeting. 1. If a non-compliance is found the nurse responsible will be immediately counseled and re-instructed din the Notification Policy. 2. If by the sixth month no non-compliance with the procedure	

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	to bilateral knees, and "immobility with movement." The hospice notes further indicated the request for a different pain medication or possible Kenalog injection for pain management. A nurse report/physician update requesting the Kenalog injection was sent on 1/1/11. A return note from the physician was received on 12/22/11 that indicated, "Could change to t#3 (Tylenol with codeine) if ok with family". The Medication Administration Record dated 12/1/11 through 12/31/11 indicated Resident #16 had no "as needed" pain medication ordered. Review of the physician orders did not indicate an as needed pain		are found, the monitoring will be discontinued. This will be reported to the Quality Assurance Committee at their quarterly meeting.	

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	medication order. On 12/27/11, a notation on the nurse report indicated, "ok with family" and was signed by LPN #3. On 12/28/11, a physician order indicated, "dc (discontinue) Tylenol. begin Tylenol #3 1 po tid...." The resident's daughter was interviewed on 2/24/11 at 1:30 p.m. She indicated she could not recall for sure the exact date the facility contacted her about trying the Tylenol #3. A signed statement from Resident #16's daughter and health care representative was provided on 2/25/11 by the DoN, which indicated she received a call a few days after			

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	Christmas regarding trying the Tylenol #3. She also indicated the knee pain was not always controlled by the current measures. The facility policy received and reviewed on 2/24/11 indicated "1.) Any change in condition requires notifying the attending physician and resident representative or the resident in a timely manner after a determination has been made that a significant change in condition has occurred." 3.1-5(a)(3)			

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F0441 SS=D	Based on observation, interview and record review, the facility failed to ensure staff followed infection control practices related to handwashing and glove use. The deficient practice affected 1 of 2 residents observed during pericare (Resident#8) from a supplemental sample of 1 and sample of 14 residents. Findings included: The clinical record for Resident #8 was reviewed on 2/24/11 at 11:20 a.m. Diagnoses included, but were not limited to: hemiplegia, aphasia, dysphagia, cerebral vascular accident, hypertension, chronic obstructive pulmonary disease, atrial fibrillation, benign prostatic hypertrophy, urinary tract infection with methicillin	F0441	1. By March 27, 2011, all direct care-giving staff will be re-inserviced on infection control practices. 2. By April 27, 2011, all direct care-giving staff will have at least one observation of their delivery of personal care observed by a licensed nurse. a. Proper adherence to infection control practices and policies will be documented in the care giver's inservice record. 3. For six months following the inservicing on infection control policies and techniques a sample of eight staff will be selected randomly each month to be observed by a professional nurse giving personal care. Emphasis will be on observing instances of hand washing, peri-care, assistance with urinals and emptying of catheter bags. Compliance with established policies and procedures will be documented, reported to the Director of Nursing and quarterly to the Quality Assurance Committee. If a violation of established infection control techniques occurs during an observation, the staff member will be immediately reinstructed on the proper technique. If three or more violations are observed during single month, a new round of instruction will be given to all direct care-giving staff. If by the last month of the six month-monitoring period, there are no non-compliances noted during any of the observations,	03/27/2011

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	staphylococcus aureus (MRSA) and urinary retention. On 2/24/11 at 10:10 a.m., an observation was made of Certified Nursing Assistant (CNA) #2 giving pericare to Resident #8. The CNA had a disposable isolation gown on, disposable face mask, and disposable gloves. The resident had been placed on the toilet with a stand lift. The CNA used the stand lift to lift the resident to a standing position from the toilet. She used a moist towelette to wash the catheter and penis, then disposed of the towelette in the hazardous waste container. Another towelette was used to wipe the rectal area and disposed of appropriately. The CNA then pulled the resident's underwear and pants up.		the monthly monitoring will be discontinued. If violations are still occurring, the monitoring period will be extended until a month with full compliance is achieved. Results of the monitioring period will be reported to the Quality Assurance Committee.4. Beginning May 1, 2011, an observation of the delivery of personal care will be documented as a part of each direct care-giver's annual evaluation.	

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	Without removing her soiled gloves, she then used the stand lift to move the resident from the bathroom to his wheelchair in the main room. The apparatus was removed from the resident and moved back to the bathroom. The CNA, still wearing the soiled gloves, then pushed the resident in his wheelchair back into the bathroom to empty the leg bag of his catheter into a disposable urinal. She then emptied and rinsed out the urinal. CNA #2 removed her face shield, gown and soiled gloves and disposed of them in the hazardous waste container. The CNA donned new			

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	disposable gloves and moved the resident to the bedside, placed the bedside table close, and placed the call light in his hand. She returned to the bathroom and removed her soiled gloves and disposed of them in the hazardous waste. The CNA then used hand sanitizer to clean her hands. An interview with the DoN on 2/24/11 at 1:55 p.m. indicated the CNA should have removed her gloves after providing the pericare, washed her hands and then donned new gloves. The facility's undated policy "Perineal Care" indicated after cleaning the anal area and patting dry, "18. Remove gloves." 3.1-18(l)			

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